

TO: Home Health Agencies

FROM: Francis T. Finnegan Jr., Director, Bureau of Medical Services

SUBJECT: Verification of eligibility form for medication services under Section 40.02-3(C)(3) Home Health Services, Maine Medical Assistance Manual.

DATE: May 18, 2000

Attached, please find a template "DMHMRSAS Client Certification for Services" form that **shall be required, effective on or after 6/5/00**, for recipients who receive medication administration and monitoring services for the treatment of severe and disabling mental illness, pursuant to Section 40 Home Health Services.

This form will document an individual's eligibility for Section 17, Community Support Services, which is a requirement for coverage of the medication services under Section 40. A community support services worker, or a physician, may complete the form, but the physician must certify its accuracy. In addition, under Section 40.02-3(C)(3), the physician must certify a statement, on the HCFA 485, that the patient's medical condition prevents the safe use of outpatient services and is contraindicated for specific reasons. The reasons must be listed and the likelihood of such a bad result must be probable or definite as opposed to possible or rarely. The expectation is that any patient, who can safely and effectively access an outpatient setting for medication services, must do so.

For each new home health medication services recipient on or after 6/5/00, submit the attached Section 17 verification form, along with the Admit/Discharge Start of Care (SOC) form to the Bureau of Elder and Adult Services. For each currently enrolled HH medication services recipient, submit the attached Section 17 verification form to BEAS at the time of the next classification reassessment date.

Anytime a recipient, who is classified for medication services, also requires any other Section 40 Home Health Service, this will trigger a medical eligibility assessment and prior authorization by the Assessing Services Agency (ASA). The Section 17 verification form must be submitted to Goold Health Systems, the ASA, along with the HCFA 485, a completed standardized referral form and a referral attachment when requesting prior authorization for services.*

Finally, signed and dated copies of the form must be maintained by the home health agency in the recipient's record. A signed and dated form shall be valid for up to 12 months. Recipients may be classified for services under Section 40.02-3(C)(3) up to 12 months, then a new classification period must be established. This form may be downloaded from the BEAS Website at www.state.me.us/dhs/beas/homehealth.

If you have any questions regarding this notice, please contact your Provider Relations Specialist at 287-3094 or 1-800-321-5557, Option 1. (For TTY call 287-1828 or 1-800-423-4331.)

FTF/jct

Attachment

*the addition of the referral attachment and the completed referral have been added.